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Notice of Independent Review Decision

December 29, 2014

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:
Reconsideration of Sleep Study related to history of head injury, headaches and cervical injury as an outpatient.

A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION:
This physician is a Board Certified Psychiatrist with over 25 years of experience.

REVIEW OUTCOME:

Upon independent review, the reviewer finds that the previous adverse determination/adverse determinations should be:

☒ Upheld (Agree)

Provide a description of the review outcome that clearly states whether medical necessity exists for each of the health care services in dispute.

PATIENT CLINICAL HISTORY [SUMMARY]:

The claimant is a male who was involved in a motor vehicle accident in which the vehicle rolled over. He sustained a head injury. Afterward, he developed generalized headaches and upper extremity and neck pain.

08/12/2014: Office Visit. **HPI:** The patient has undergone lumbar and cervical epidural steroid injections and will undergo a thoracic epidural steroid injection tomorrow. A cervical rhizotomy is planned in two weeks. The patient describes left retroorbital and circumferential pain. He has a sensation that there is something in his left eye. He describes a hot poker. He has been prescribed Elavil, which seems to help. He reports that his pain can be reduced if pressure is applied to the eye. He reports double vision, which appears to be skewed vision. This occurs once or twice daily. **Past Medical History:** Positive for partial discectomy in the lumbar spine December, 2012. Right knee arthroscopy. **Present Medications:** Flexeril, Elavil 25 mg at bedtime, Norco, and Prodrin. **Neurological Examination:** He appears healthy. Blood pressure is unobtainable. Height is 5'11. Weight is 285

lbs. Cranial nerves III-XII were normal with no observable extraocular muscle weakness. The motor examination shows intact muscle bulk, tone, strength, and tendon reflexes on all extremities. Station, gait, and tandem gait were normal. His medical records were reviewed. A CT scan of the head dated September 4, 2013 was normal. An MRI of the lumbar spine showed disk protrusion at L3-4 and L4-5. An MRI of the thoracic spine in September, 2013 showed a disk protrusion at T7-8 and T9-10 and neural foraminal narrowing at T10-11. An MRI scan of the cervical spine showed degenerative disease at multiple levels with canal stenosis from C4 through C6. **Assessment:** This patient's complaint of headache and double vision is most likely due to a post-concussion syndrome resulting from his head injury. His complaint of headache is consistent with this injury as well. **Plan:** We discussed increasing his dose of amitriptyline for better headache prophylaxis and he agreed. A 50mg dose was prescribed and a follow-up was scheduled.

10/14/2014: Office Visit. **HPI:** Patient is using Prodrin once, sometimes twice per day. He is still with blurred vision, which appeared two days after his injury. He saw an ophthalmologist who attributed his diplopia to eyestrain. **Examination:** Blood pressure is unobtainable. Cranial nerves are intact. No extraocular muscle weakness was observed. Motor examination, tendon reflexes, cerebellar, station and gait examinations are normal. **Assessment:** His post-traumatic headache has improved with amitriptyline but he reports drowsiness. Prodrin is effective for acute headache treatment. **Plan:** Nortriptyline will be substituted for amitriptyline as this medication has fewer side effects. He will continue Prodrin. Follow Up in four weeks.

11/10/2014: Office Visit. **HPI:** Pt reports that he had cervical and lumbar rhizotomies that helped his neck and low back pain. He also had an injection into his left shoulder. He reports that he continues to use Nortriptyline, 30 mg at bedtime but it causes heartburn. He treats this with an antacid medication but he cannot recall the name. His headaches no longer appear daily. He still uses Prodrin. He reports that he is suspicious that he has obstructive sleep apnea. He feels that his symptoms, "loud snoring" appeared after the injury and not before. **Assessment:** His post-traumatic headaches are somewhat better with Nortriptyline but he reports gastrointestinal side effects. He may have obstructive sleep apnea which can be associated with cervical spinal cord injuries. **Plan:** Prilosec will be added. He may also dose Nortriptyline in the mornings. We will see if he may undergo a sleep study for suspected sleep apnea.

11/19/2014: UR. **Rationale for Denial:** The claimant is a male with the date of injury of xx/xx/xx. The claimant was involved in a rollover accident sustaining an injury to his head resulting in frequent headaches which seemed to be under control and seemed to be improving. The request is for a sleep study related to history of head injury, headaches and cervical injury. I had a peer-to-peer conversation with requesting physician, a neurologist who sees him for his posttraumatic headaches. The medical information indicates that the claimant has noted snoring that did not occur prior to his injury. was considering the possibility of central sleep apnea. We discussed the fact that there is no evidence whatsoever of any type of cervical spinal cord injury. There is also no information

regarding excessive daytime sleepiness, whether this claimant is overweight or not overweight, whether the claimant is a smoker and whether there is impaired function secondary to any of these issues. Based on the information and my peer conversation the request is recommended for non-certification as being not medically reasonable or necessary.

12/05/2014: UR. **Rationale for Denial:** This is a male who was injured on xx/xx/xx. The progress note dated November 10, 2014 indicates that the injured worker has a history of trauma and posttraumatic headaches. The injured worker also has a history of cervical and lumbar rhectomy which improved both neck and low back pain. An injection has also been provided to the left shoulder. The injured worker is utilizing Nortriptyline but this has resulted in heart burn. The headaches are documented as having decreased in frequency. The injured worker notes suspicion of underlying obstructive sleep apnea and indicates the symptoms of “loud snoring” appeared following the injury but were not present before. Vital signs were not obtained. It is unclear if the injured worker has history of smoking. The clinician notes that the injured worker may have obstructive sleep apnea which can be associated with cervical spinal cord injuries. There is no documented evidence of a spinal cord injury having occurred. The injured worker does not endorse any daytime somnolence. A previous progress note dated October 14, 2014 also fails to address the above noted deficiencies.

12/09/2014: Office Visit. **HPI:** Patient reports headaches have improved with Nortriptyline. They are less frequent. Previously, they were appearing every morning but now appear four or five times a week and they are mild. They may last throughout the day and he will treat them with Prodrin. **Assessment:** His headaches have proved. He does not report side effects of Nortriptyline. **Plan:** Nortriptyline will be increased to 75 mg daily.

ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS, AND CONCLUSIONS USED TO SUPPORT THE DECISION:

The previous adverse determinations are upheld. There is nothing to indicate that his “loud snoring” is at all associated with the head trauma. There are many reasons for loud snoring including increased somnolence with the Nortriptyline. Other criteria for a sleep study are not identified. For these reasons, Reconsideration of Sleep Study related to history of head injury, headaches and cervical injury as an outpatient is not medically necessary at this time and should be denied.

Criteria for Polysomnography:
Polysomnograms / sleep studies are recommended for the combination of indications listed below: (1) Excessive daytime somnolence;
(2) Cataplexy (muscular weakness usually brought on by excitement or emotion, virtually unique to narcolepsy);
(3) Morning headache (other causes have been ruled out);
(4) Intellectual deterioration (sudden, without suspicion of organic dementia);

(5) Personality change (not secondary to medication, cerebral mass or known psychiatric problems);
(6) Sleep-related breathing disorder or periodic limb movement disorder is suspected;
(7) Insomnia complaint for at least six months (at least four nights of the week), unresponsive to behavior intervention and sedative/sleep-promoting medications and psychiatric etiology has been excluded. A sleep study for the sole complaint of snoring, without one of the above mentioned symptoms, is not recommended;
(8) Unattended (unsupervised) home sleep studies for adult patients are appropriate with a home sleep study device with a minimum of 4 recording channels (including oxygen saturation, respiratory movement, airflow, and EKG or heart rate).

A DESCRIPTION AND THE SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE THE DECISION:

- ☐ **ACOEM- AMERICAN COLLEGE OF OCCUPATIONAL & ENVIRONMENTAL MEDICINE UM KNOWLEDGEBASE**
- ☐ **AHCPR- AGENCY FOR HEALTHCARE RESEARCH & QUALITY GUIDELINES**
- ☐ **DWC- DIVISION OF WORKERS COMPENSATION POLICIES OR GUIDELINES**
- ☐ **EUROPEAN GUIDELINES FOR MANAGEMENT OF CHRONIC LOW BACK PAIN**
- ☐ **INTERQUAL CRITERIA**
- ☒ **MEDICAL JUDGEMENT, CLINICAL EXPERIENCE, AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS**
- ☐ **MERCY CENTER CONSENSUS CONFERENCE GUIDELINES**
- ☐ **MILLIMAN CARE GUIDELINES**
- ☒ **ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES**
- ☐ **PRESSLEY REED, THE MEDICAL DISABILITY ADVISOR**
- ☐ **TEXAS GUIDELINES FOR CHIROPRACTIC QUALITY ASSURANCE & PRACTICE PARAMETERS**
- ☐ **TEXAS TACADA GUIDELINES**
- ☐ **TMF SCREENING CRITERIA MANUAL**
- ☐ **PEER REVIEWED NATIONALLY ACCEPTED MEDICAL LITERATURE (PROVIDE A DESCRIPTION)**
- ☐ **OTHER EVIDENCE BASED, SCIENTIFICALLY VALID, OUTCOME FOCUSED GUIDELINES (PROVIDE A DESCRIPTION)**